

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-013711

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3346

STATE FILE NUMBER

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If outside, give location) 3833 Virginia	
3. NAME OF DECEASED (Type or print) First Middle Last Wincenty (Piskorski) Piskorowski		4. DATE OF DEATH Month Day Year March 20, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-18-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME Unknown		11b. MOTHER'S MAIDEN NAME Unknown	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		12b. SOCIAL SECURITY NO. 331X	
13a. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		13b. NAME OF HUSBAND OR WIFE Lottie Piskorowski	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		14. CITIZEN OF WHAT COUNTRY U. S. A.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Helen L. Taylor, Coroner		22b. ADDRESS 1300 Clark Ave.	
22c. DATE SIGNED 3-22-63		22d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 23 1963	
23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR ADDRESS ST. LOUIS FUNERAL HOME		25. DATE RECD. BY LOCAL REG. MAR 22 1963	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No.

3749

P. O. Address

St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.